TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Doctors Hospital at Renaissance

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-17-2260-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 27, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount.

After reviewing the account we have concluded that reimbursement received was inaccurate."

Amount in Dispute: $107.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the EOB(s) and the reduction rationale(s) stated therein. Note the further explanation in the attached email dated 4/5/17 from Marion B. Kirk. The Texas Labor Code requires reimbursement for all medical expenses to be fair and reasonable and be designed to ensure the quality of medical care and to achieve effective medical cost control."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 03, 2016	Outpatient Hospital Services	$107.20	$1.98

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - W3 – Additional payment made on appeal/reconsideration
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
   - 947 – Upheld. No additional allowance has been recommended
   - 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
2. This dispute relates to outpatient hospital facility services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules, which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code 96361 has status indicator S, denoting significant outpatient procedures paid by APC, not subject to reduction. This is assigned APC 5691. The OPPS Addendum A rate is $30.87. This is multiplied by 60% for an unadjusted labor-related amount of $18.52, which is multiplied by the facility wage index of 0.8026 for an adjusted labor amount of $14.86. The non-labor related portion is 40% of the APC rate, or $12.35. The sum of the labor and non-labor portions is $27.21. The cost of these services does not exceed the fixed-dollar threshold of $3,250. The outlier payment is $0. The Medicare facility specific reimbursement of $27.21, is multiplied by 200% for a MAR of $54.42.
   - Procedure code 80048 has status indicator Q4, denoting packaged labs; reimbursement is included in APC payment for primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
   - Procedure code 85025 has status indicator Q4, denoting packaged labs; reimbursement is included in APC payment for primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.

- Procedure code 85610 has status indicator Q4, denoting packaged labs; reimbursement is included in APC payment for primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 85730 has status indicator Q4, denoting packaged labs; reimbursement is included in APC payment for primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 81001 has status indicator Q4, denoting packaged labs; reimbursement is included in APC payment for primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 74020 has status indicator Q1, denoting STV-packaged codes; reimbursement for these services is packaged with the payment for any procedures with status indicator S, T or V. These services are separately payable only if no other such procedures are billed.
- Procedure code 99284 has status indicator J2, denoting hospital, clinic or emergency room visits (including observation/critical care services) subject to composite payment if certain other services are billed in combination. This is assigned APC 5024. The OPPS Addendum A rate is $326.99. This is multiplied by 60% for an unadjusted labor-related amount of $196.19, which is multiplied by the facility wage index of 0.8026 for an adjusted labor amount of $157.46. The non-labor related portion is 40% of the APC rate, or $130.80. The sum of the labor and non-labor portions is $288.26. The cost of these services does not exceed the fixed-dollar threshold of $3,250. The outlier payment is $0. The Medicare facility specific reimbursement of $288.26, is multiplied by 200% for a MAR of $576.52.
- Procedure code J2270 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
- Procedure code J7040 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
- Procedure code A9270 has status indicator E, denoting excluded or non-covered codes not payable on an outpatient bill. Payment is not recommended.
- Procedure code 96374 has status indicator S, denoting significant outpatient procedures paid by APC, not subject to reduction. This is assigned APC 5693. The OPPS Addendum A rate is $92.40. This is multiplied by 60% for an unadjusted labor-related amount of $55.44, which is multiplied by the facility wage index of 0.8026 for an adjusted labor amount of $44.50. The non-labor related portion is 40% of the APC rate, or $36.96. The sum of the labor and non-labor portions is $81.46. The cost of these services does not exceed the fixed-dollar threshold of $3,250. The outlier payment is $0. The Medicare facility specific reimbursement of $81.46, is multiplied by 200% for a MAR of $162.92.

4. The total recommended reimbursement for the disputed services is $793.86. The insurance carrier has paid $791.88 leaving an amount due to the requestor of $1.98. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1.98.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1.98 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		4/28/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.